



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: RENAISSANCE HOSPITAL C/O BURTON & HYDE PLLC PO BOX 684749 AUSTIN TX 78768-4749	MFDR Tracking #: M4-07-4495-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: NEW HAMPSHIRE INSURANCE COMPANY Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the fair and reasonable reimbursement amount for this hospital outpatient admission should at least be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."

Amount in Dispute: \$7,441.53

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Respondents position that the Requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the **ACT**. Specifically, the amount paid by the Respondent was more than that which would be allowed under Medicare. Respondent has paid Requestor \$1118.00 which is the same amount that a full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization... As the Requestor, the health care provider has the **burden to proof** [sic] that the fees paid were not fair and reasonable... In summary the Requestor was paid more than a **fair and reasonable** amount as determined in accordance with the criteria for payment under the **ACT** and is not entitled to additional reimbursement from Hartford Insurance Co."

Response Submitted by: The Hartford, 300 S. State St., Syracuse, NY 13202

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
3/22/2006	W10, 193	Outpatient Surgery	\$7,441.53	\$2,448.99
			Total Due:	\$2,448.99

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on March 19, 2007.

1. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the Claim Adjudication Process as to the Workers' Compensation Receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 Trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.

2. By letter dated May 26, 2011, the attorney for the requestor provided *REQUESTOR'S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – DALLAS)* that specified, in pertinent parts, an "Additional Reimbursement Amount Owed" of \$2,448.99 and an "alternative" "Additional Reimbursement Amount Owed" of \$5,641.42. The Division notes that the amount in dispute of \$7,441.53 specified in Part IV above is the original amount in dispute as indicated in the requestor's *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR'S AMENDED POSITION STATEMENT*.
3. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REDUCED TO FAIR AND REASONABLE.
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. FINAL ACTION. IN ACCORDANCE WITH RULE 133.250 (G): "A HEALTH CARE PROVIDER SHALL NOT RESUBMIT A REQUEST FOR RECONSIDERATION AFTER THE CARRIER HAS TAKEN FINAL ACTION ON THE REQUEST."
4. This dispute relates to services with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's amended position statement asserts that "the fair and reasonable reimbursement amount for this hospital outpatient admission should at least be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."
 - In support of the requested reimbursement methodology the requestor states that "Ordering additional reimbursement based on the average amount paid system-wide in Texas achieves effective medical cost control because it prevents overpayment... creates an expectation of fair reimbursement; and... encourages health care providers to continue to offer quality medical care to injured employees... Ordering additional reimbursement for at least the average amount paid for a hospital outpatient admission during the same year of service and involving the same Principal Diagnosis Code and Principal Procedure Code ensures that similar procedures provided in similar circumstances receive similar reimbursement... The average amount paid for similar admissions as put forward by the Requestor is based on a study of data maintained by the Division."
 - The requestor submitted documentation to support the state-wide, annual, average reimbursement in Texas for the principal diagnosis code and principal procedure code of the disputed services during the year that the services were rendered.
 - The requestor has explained and supported that the requested reimbursement methodology would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as the disputed admission for those admissions involving the same principal diagnosis code and principal procedure code is a fair and reasonable rate of reimbursement for the services in dispute.

7. In the alternative, the requestor proposes that "it is also justifiable to order as much in additional reimbursement as is owed under the Hospital Facility Fee Guidelines – Outpatient because the Division's new fee guidelines, while not in effect at that time, are presumptively fair and reasonable reimbursement under the law and data from the Medicare Outpatient Prospective Payment System for these dates of service is still available for calculating the amount due." Review of the submitted documentation finds that:
 - In support of the alternative requested reimbursement methodology the requestor states that "The data necessary to calculate the Maximum Allowable Reimbursement is readily available from the Medicare Outpatient Prospective Payment System. Therefore, the new fee guidelines as adopted in 28 TEX. ADMIN. CODE § 134.403 provide a presumptive measure for the fair and reasonable reimbursement amount."
 - The requestor did not submit documentation to support the Medicare payment calculation for the services in dispute.
 - The fee guidelines as adopted in Division rule at 28 TAC §134.403 were not in effect during the time period when the disputed services were rendered.

- The Division disagrees that the fee guidelines as set forth in §134.403 are “presumptively fair and reasonable reimbursement under the law” for dates of service prior to the date the rule became effective. No documentation was found to support such a presumption under law.
- While the Division has previously found that Medicare patients are of an equivalent standard of living to workers’ compensation patients, (22 TexReg 6284, July 4, 1997), Texas Labor Code Section 413.011(b) requires that “In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d)... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.”
- The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in Division rule at 28 TAC §134.403, effective for dates of service on or after March 1st, 2008, would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.
- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the alternative requested reimbursement.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for the alternative additional amount of \$5,641.42 is not supported. The requestor has not demonstrated or presented sufficient documentation to support that the alternative additional amount requested of \$5,641.42 would provide a fair and reasonable rate of reimbursement for the services in dispute.

8. Division rule at 28 TAC §133.307(d)(2)(A)(iv)(V), effective December 31, 2006, 31 TexReg 10314, applicable to requests filed on or after January 15, 2007, requires the respondent to provide “documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 of this title if the dispute involves health care for which the Division has not established a MAR, as applicable.” Review of the submitted documentation finds that:
 - The respondent’s position statement asserts that “The Carrier paid Fair and Reasonable which is the same as those used by the Texas Workers’ Compensation Commission under Rule 134.401 in which the claimant would be receiving 24 hour care as a surgical inpatient for one day.”
 - The Division notes that the inpatient per diem rate is not applicable to the services in this dispute; per §134.401(a)(4), outpatient surgical care is not covered by that guideline and shall be reimbursed at a fair and reasonable rate.
 - The respondent’s position statement asserts that “the amount paid by the Respondent was more than that which would be allowed under Medicare.”
 - The respondent did not submit documentation to support that the amount paid by the Respondent was more than that which would be allowed under Medicare for the services in dispute.
 - Furthermore, while the Division has previously found that Medicare patients are of an equivalent standard of living to workers’ compensation patients, (22 TexReg 6284, July 4, 1997), Texas Labor Code Section 413.011(b) requires that “In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d)... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.”
 - The respondent’s position statement asserts that “Respondent has paid Requestor \$1118.00 which is the same amount that a full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization.”
 - The respondent did not explain or demonstrate how the services in dispute are comparable to a spinal surgery and a one-day inpatient hospitalization.
 - The respondent did not submit documentation to support that the services in dispute are comparable to a spinal surgery and a one-day inpatient hospitalization.
 - The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute.
 - The respondent did not support that the amount paid satisfies the requirements of Division rule at 28 TAC §134.1.

The respondent’s position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of Division rule at 28 TAC §133.307(d)(2)(A)(iv)(V).

9. The Division finds that the documentation submitted in support of the fair and reasonable methodology proposed by the requestor based on the average amount paid by all insurance carriers in the same year for admissions involving the same principal diagnosis code and principal procedure code as the services in dispute is the best evidence in this dispute of an amount that will achieve a fair and reasonable reimbursement for the services in this dispute. Reimbursement will therefore be calculated as follows. Review of the medical bill finds that the principal diagnosis code for the disputed services is 836.1. The principal procedure code is 80.6. The requestor submitted documentation to support that the average, state-wide reimbursement for this diagnosis code and procedure code performed in 2006 was \$3,566.99. This amount less the amount previously paid by the respondent of \$1,118.00 leaves an amount due to the requestor of \$2,448.99. This amount is recommended.
10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has established that additional reimbursement is due. The Division concludes that the carrier's response was not submitted in the form and manner prescribed under Division rule at 28 Texas Administrative Code §133.307(d). The Division further concludes that the respondent failed to support that the amount paid by the insurance carrier is a fair and reasonable reimbursement in accordance with Division rule at 28 Texas Administrative Code §134.1. As a result, the amount ordered is \$2,448.99.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$2,448.99 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.803, due within 30 days of receipt of this order.

ORDER:

_____ Authorized Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	8/11/2011 Date
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PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.